



# CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

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<b>4.1.3 SCHEDULING AND ACCESS TO CARE PROCEDURE</b>	Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

## I. PROCEDURE OVERVIEW

This procedure describes the systems and processes which California Correctional Health Care Services (CCHCS) staff shall utilize to optimize access to care and maintain an effective and efficient scheduling system to ensure timely patient access to health care services. This includes a flexible appointment system that accommodates various encounter appointment types, encounter lengths, same-day encounters, and scheduled follow-ups as well as strategies to increase efficiency, such as consolidated appointments. This procedure also specifies roles and responsibilities for key staff involved in the scheduling system.

## II. DEFINITIONS

**Backlog:** An undesirable condition that occurs when today's work (both the planned work and work that is unplanned, but needs to be accomplished by today) is not completed today.

**Care Team:** An interdisciplinary group of health care professionals who combine their expertise and resources to provide care for a panel of patients.

**Clinic Manager:** The Supervising Registered Nurse (RN) II who is assigned to the clinic.

**Ducat:** A common term for a CDC 129, Inmate Pass. There are two types of ducats, "Priority" and "Non-Priority." Priority ducats are stamped with the word "Priority" and are used for scheduled health care appointments. Non-Priority ducats are used for unscheduled appointments and/or unescorted movement from one location to another.

**Encounter Consolidation** (sometimes referred to as bundling or stacking): When a patient has multiple pending appointments, setting appointments sequentially on the same day so that a patient need only be seen in one encounter for multiple purposes. Encounter consolidation helps increase clinic efficiency, meet mandated timeframes, and limit the need for custody escorts, lessening redundant work for custody and health care staff as well as making appointments more convenient for the patient.

**Interventions:** Actions that focus on the execution of the specific care management activities that are necessary for accomplishing the goals set forth in the patient's treatment plan, linking the patient to the services needed to optimize health.

**Non-Business Days:** Saturdays, Sundays and State holidays.

**Normal Business Hours:** A minimum of eight hours per business day. These hours may vary by institution, but are generally between the hours of 0700 and 1800.

**Open Access:** A scheduling strategy that involves "doing today's work today" and seeing patients as soon as possible after they request care, and on the same day if appropriate. Open access slots are appointment times or blocks that are left open and unscheduled until one to two days prior to that date, allowing the Care Team to accommodate walk-in patients, patients with urgent health needs, and patients with routine health needs that would benefit from expedited services.

**Scheduling Support Staff:** The member of the Care Team who ensures that all patients are appropriately scheduled and that Care Team members have the information they need for planned patient encounters. This is usually administrative support staff.

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## III. RESPONSIBILITIES

### A. Statewide

California Department of Corrections and Rehabilitation (CDCR) and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available to ensure the scheduling system is successfully implemented and maintained.

### B. Regional

Regional Health Care Executives are responsible for implementation of this procedure at the subset of institutions within an assigned region.

### C. Institutional

1. The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of the scheduling system at the institution and patient panel level. The CEO delegates decision-making authority to the Chief Nurse Executive (CNE) for daily operations of the scheduling system and ensures adequate resources are deployed to support the system including, but not limited to the following:
  - a. Ensuring access to and utilization of equipment, supplies, health information systems, Patient Registries, Patient Summaries, and evidence-based guidelines.
  - b. Assigning patients to a Care Team.
  - c. Maintaining a list of the core members of each Care Team, which shall be available to all institutional staff. Patients shall be informed of their assigned Care Team members at intake and/or upon request.
  - d. Ensuring consistent Care Team staffing with a back-up system for core members.
  - e. Providing Care Team members with the information they need during huddles (e.g., communication of on-call information).
  - f. Ensuring protected time for Care Teams to hold daily huddles.
  - g. Documenting and tracking huddle actions and attendance.
  - h. Ensuring that at least monthly, each Care Team conducts a Population Management Working Session utilizing tools such as Dashboards, Patient Registries, and Patient Summaries to address concerns related to potential gaps in care and improved patient outcomes including, but not limited to:
    - 1) High risk patients.
    - 2) Contract Management.
    - 3) Patient safety alert.
    - 4) Trends in access to care.
    - 5) Surveillance of communicable disease.
    - 6) Patient risk stratification.
    - 7) Data entry completeness and accuracy.
  - i. Adequately preparing new Care Team members to assume team roles and responsibilities.
  - j. Assessing competence of existing Care Team members.
  - k. Updating institution procedures, roles, and responsibilities as new tools and technology become available.
  - l. Reviewing/comparing institution Care Team performance including the overall quality of services, health outcomes, assignment of consistent and adequate resources; utilization of Dashboards, Patient Registries, Patient Summaries, and decision support tools; and addressing issues as necessary.

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- m. Providing Care Team members with adequate resources including protected time, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
  - n. Working with custody staff to minimize unnecessary patient movement resulting in changes to a patient's panel assignment.
  - o. Ensuring, in collaboration with the Warden, that the institution establishes a Local Operating Procedure by which priority health care ducats are issued and delivery by custody staff is verified and documented.
  - p. Requiring institution leadership to establish a back-up system to ensure that scheduling queues are managed when Scheduling Support Staff are on leave or otherwise unable to meet daily monitoring requirements.
2. The CEO and all members of the institution leadership team are responsible for establishing an organizational culture that promotes teamwork among Care Team members and across disciplines.
3. The CEO and institution leadership team shall review institution-wide scheduling and access to care data monthly in the context of local Quality Management Committee and subcommittee meetings.
4. To ensure accuracy of scheduling system data, the institution leadership team shall:
  - a. Periodically evaluate the reliability of scheduling system data through comparison with independent data sources, such as movement or ducat reports and progress notes, or audits for abnormal or incomplete entries.
  - b. Take effective action to remedy unreliable data, including creating or revising decision support, updating desk procedures, and redesigning orientation and training strategies.
  - c. Re-validate problematic data monthly until the data reliability issue is resolved.
5. Local quality improvement forums shall take action as appropriate to investigate quality problems and develop interventions to improve access.
6. The CNE is responsible for:
  - a. The overall daily operations of the scheduling system for medical care.
  - b. The coordination of health care services between health care scheduling systems.
  - c. Oversight and management of scheduling processes and resources including personnel.
  - d. Ensuring that the institution has a designated Scheduling Supervisor to monitor scheduling processes on a daily basis and identify and address or elevate barriers to access.
  - e. Ensuring that Scheduling Support Staff is available for all clinical areas.
7. The Chief Medical Executive (CME) is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.
8. At least monthly, the CME and CNE shall review the following in each Primary Care Clinic to determine if adjustments need to be made to the overall clinic schedule plan to meet patient care needs:
  - a. Scheduling Diagnostic Report.
  - b. Schedule plan.
  - c. Utilization of open access time and co-consultation.
  - d. Number of additional "add-on" appointments.
  - e. Current backlog.

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9. The Supervising RN and Chief Physician and Surgeon shall meet to review the Care Teams' performance including the overall quality of services, health outcomes, and level of care utilization and shall utilize Dashboards, Patient Registries, Patient Summaries, and decision support tools to address or elevate issues as necessary.
10. Institution leadership shall designate a standing committee reporting to the local Quality Management Committee for oversight of the scheduling system.
11. The Scheduling Supervisor and Clinic Manager
  - a. The Scheduling Supervisor shall review select information daily to identify and immediately address scheduling system problems.
  - b. The Scheduling Supervisor shall determine whether all Scheduling Support Staff, Primary Care RNs, and Primary Care Providers (PCPs) are in attendance at their respective clinics that day, and shall verify that appropriate back-up has been provided if any of these staff are unavailable.
  - c. The Scheduling Supervisor shall review scheduling management reports on a daily basis including, but not limited to, the following:
    - 1) Scheduling system diagnostic data to identify data entry errors and appointment trends.
    - 2) Scheduling queues not managed properly.
    - 3) Duplicate appointments.
    - 4) Unscheduleable appointments.
    - 5) Unorthodox clinic scheduling practices and other scheduling system problems.
  - d. The Scheduling Supervisor shall review clinic scheduling strategies to ensure that clinics are optimizing strategies such as open access, encounter consolidation, and co-consultation.
  - e. The Scheduling Supervisor shall work with the Clinic Manager to improve communication processes within the Care Team and across health care settings that impact scheduling and access, including daily huddles.
  - f. The Clinic Manager and Scheduling Supervisor are responsible for providing frequent feedback to health care staff involved in the scheduling system on their individual performance based upon findings from daily observation of scheduling processes.
12. The Care Team
  - a. At least monthly, the Care Team shall evaluate the effectiveness and efficiency of scheduling processes and overall access to care. The Care Team shall consider trends in the following:
    - 1) Adherence to access timeframes.
    - 2) Proportion of appointments seen as scheduled and reasons patients were not seen as scheduled.
    - 3) Episodic Care referral rates to the PCP.
    - 4) Effectiveness of scheduling strategies, such as open access, encounter consolidation, and co-consultation.
    - 5) Design of clinic schedules (e.g., number of open access slots, allotting certain time blocks for different appointment types).
    - 6) Productivity.
    - 7) Demand management, including episodic care, chronic care, chronos, medication refusals and other types of non-adherence counseling, and grievances.

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- 8) Allocation of work across team members.
- 9) Clinic closures.
- 10) Specialty provider network issues.
- 11) Completeness and accuracy of scheduling data.
- 12) Security and construction impacts to access.
- 13) Population management health care alerts.
- b. The Care Team shall take corrective action to resolve and/or elevate concerns identified in the review. The Care Team review and corrective action shall be documented and forwarded to the designated committee.
13. All health care staff shall be trained in scheduling and access to care concepts and principles. Targeted training shall be provided to those who have specific roles in the scheduling process (e.g., providers, nurses, schedulers). A system for the orientation, mentoring, and cross-training of all critical positions in the scheduling system shall be maintained.
14. Each institution shall ensure all Scheduling Support Staff have a desk procedure with guidance on how to accurately and effectively employ the scheduling system with information tailored to different work locations and scheduling functions. The desk procedure shall be updated as scheduling processes change.
15. Each institution shall develop or adopt decision support tools (e.g., forms, checklists, cards that can be taped to a computer monitor) to prompt health care staff in different roles in the scheduling system to fulfill their roles and responsibilities including, but not limited to, the following:
  - a. Prompting clinic staff to communicate clearly to Scheduling Support Staff.
  - b. Giving tips on how to enter data in a way that is recognized by the scheduling system.
  - c. Reminding Scheduling Support Staff and clinic staff of new scheduling procedures and updated access to care timeframes.
16. Staff involved in the scheduling system shall receive training on changes to scheduling processes and tools as they evolve and periodic refresher training on their particular roles and responsibilities.

## IV. GENERAL SCHEDULING CONCEPTS

### A. Standardized Scheduling System

All institutions shall use the standardized statewide scheduling system.

### B. Scope of the Scheduling Process

The scheduling process shall begin upon a patient's arrival at CDCR and continue throughout the patient's stay.

### C. Scheduling System User Designations and Accessibility

Staff shall submit a Solution Center ticket to add or change a provider or location.

## V. ACCESS TO HEALTH CARE SERVICES

### A. Hours of Access

1. All CDCR inmates shall have access to medically necessary health care services 7 days per week, 24 hours per day.
  - a. RNs shall be onsite at the institution 7 days per week, 24 hours per day.
  - b. Medical, mental health, and dental services shall be available at any time.

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2. Each institution shall establish hours of operation for Primary Care Clinics, generally at least eight hours per day, Monday through Friday, excluding State holidays.

## **B. Methods of Access**

1. Licensed Health Care Initiated Appointments  
Access to care includes planned health care encounters scheduled over time at appropriate intervals and initiated by licensed health care staff as part of ongoing treatment planning and care management to address health care needs.
2. Patient Request for Services:
  - a. Access to care also includes episodic encounters requested by patients either through written request, verbal report, or demonstration of urgent/emergent health care needs.
  - b. At any time, patients with health care needs may submit a CDCR 7362, Health Care Services Request Form. Patients with urgent health care needs may complete a CDCR 7362 or notify any institutional staff, including correctional staff for assistance. Patients with life-threatening conditions shall receive immediate medical attention.
  - c. If a patient is unable to complete a CDCR 7362, health care staff shall complete the form on behalf of the patient. Health care staff shall document the complaint and the reason the patient did not personally complete the CDCR 7362 and shall sign and date the CDCR 7362.
  - d. Institutions shall ensure the CDCR 7362 is available to patients in the housing units, clinics, and Reception Centers. Housing unit staff and health care staff shall make the CDCR 7362 available upon request. Each institution shall have at least one locked box on each yard/facility designated for patients to deposit the CDCR 7362.
3. Initial Review and Triage of a CDCR 7362
  - a. On normal business days:
    - 1) A designated health care staff member on each yard/facility shall collect the CDCR 7362s from the designated areas, document the date and time of pickup, and deliver the forms to the Primary Care RN for review.
    - 2) The Primary Care RN shall review each CDCR 7362 and identify those that describe symptoms of a medical, mental health, or dental condition. The Primary Care RN shall determine whether the patient requires urgent/emergent or routine care. The RN shall immediately refer urgent/emergent medical, mental health, and dental needs to the appropriate clinician for evaluation consistent with established program guidelines.
    - 3) Patients who submit CDCR 7362s that describe symptoms shall be seen by the Primary Care RN within one business day.
    - 4) If the Primary Care RN determines a PCP referral is necessary, the patient shall be seen based on the following timeframes:
      - a) Emergency – immediately
      - b) Urgent – within 24 hours
      - c) Routine – within 14 calendar days
    - 5) The Primary Care RN shall separately address CDCR 7362s that do not include symptoms, such as requests for eyeglasses or medication renewals, routing them to appropriate staff. CDCR 7362s that do not describe symptoms shall be delivered the same day to the designated program representative on normal business days.

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- 6) A CDCR 7362 requesting services from more than one area (e.g., medical and dental) shall be copied and delivered to the requested service areas by the RN reviewing the CDCR 7362.
  - b. On non-business days:
    - 1) All CDCR 7362s shall be sent to the Triage and Treatment Area (TTA) RN for triage. Upon receipt of the CDCR 7362s, the TTA RN shall review, initial, and date each. The TTA RN shall ensure that the routine CDCR 7362s are delivered to the Primary Care RN that is assigned to that patient by the beginning of the next business day.
    - 2) The TTA RN shall determine whether the patient requires urgent/emergent or routine care and shall take direct action to coordinate care for patients with emergency or urgent conditions. The TTA RN shall immediately refer urgent/emergent medical, mental health, and dental needs to the appropriate clinician for evaluation consistent with established program guidelines.
4. Emergency Care Required
  - a. Patients with life-threatening medical symptoms shall receive immediate medical attention pursuant to Inmate Medical Services Policies and Procedures (IMSP&P), Volume 4, Chapter 12, Emergency Medical Response System Policies and Procedures.
  - b. For patients with a potential mental health and/or dental urgent/emergent condition during normal business hours, the Primary Care RN shall immediately assess the patient and communicate findings directly with designated mental health and/or dental staff.
  - c. The Primary Care RN shall ensure immediate transportation of the patients to the designated area for evaluation and treatment. When a patient is referred to the mental health program, the CDCR 7362 shall be forwarded and a Mental Health Consultation ordered.
  - d. Patients with a potential mental health emergency (i.e., danger to self or others) must remain under continuous observation until the patient is evaluated by a mental health clinician or by TTA medical staff.
5. Urgent Care Required
  - a. Patients with urgent medical symptoms shall be scheduled for a same day face-to-face encounter with the Primary Care RN and other members of the Care Team as indicated by symptoms.
  - b. For patients with urgent symptoms involving more than one clinical discipline, the Primary Care RN shall ensure any urgent medical, dental, and/or mental health conditions are evaluated as described above.
  - c. When the patient requests services from more than one clinical discipline (e.g., medical and dental) on the CDCR 7362, health care staff shall copy and forward the request to the other clinical disciplines as soon as possible. The original shall be forwarded to the first requested service area.

## VI. SCHEDULING STRATEGIES

CCHCS staff shall use strategies such as open access, encounter consolidation, co-consultation, and collaborative planning of the clinic schedule to optimize access to medical services.

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## A. Services that Require Appointments

1. Health care encounters shall be considered appointments and shall be ordered and scheduled within the Electronic Health Record System including, but not limited to, the following encounter reasons:
  - a. Episodic care encounters, including Primary Care RN encounters and provider referrals.
  - b. Well patient encounters.
  - c. Chronic care follow-up appointments.
  - d. Specialty services.
  - e. Care management encounters.
  - f. Interdisciplinary treatment planning sessions.
  - g. Recurring patient monitoring or follow-up appointments, such as dressing changes and blood pressure checks.
  - h. Injection appointments.
  - i. Public health screening and treatments.
  - j. Patient education and non-adherence counseling.
  - k. Special situations such as hunger strike evaluations and monitoring.
  - l. Follow up after return from a higher level of care.
  - m. Health care grievances.
2. In the event a patient transfers to another institution, the Care Team shall ensure that existing health care appointments, including specialty referrals, are rescheduled at the receiving institution as indicated. All members of the Care Team shall ensure that follow-up appointments are continued in Orders Reconciliation including, but not limited to, the following:
  - a. TTA encounters.
  - b. Receiving and Release intake.
  - c. Discharge from a higher level of care.

## B. Translation Services

Translation services (including sign language) shall be made available to patients as necessary via certified bilingual health care staff, certified bilingual CDCR staff, or by utilizing a certified interpretation service. Each institution shall maintain a contract for certified interpretation services pursuant to IMSP&P, Volume 1, Chapters 28.1 and 28.2, Effective Communication Policy and Procedure.

## C. Scheduling

1. General Requirements
  - a. Health care staff shall ensure that lists for scheduled appointments are communicated to custody staff no later than one business day prior to the scheduled encounter.
  - b. Each institution shall establish a procedure by which health care ducats are issued as priority ducats and delivery by custody is verified/documented. This procedure shall include the following:
    - 1) The method by which priority health care ducats are delivered to each patient.
    - 2) The individual responsible for issuing priority health care ducats.
    - 3) Verification by custody staff that the priority health care ducats were issued to the patient.
    - 4) A method of re-routing priority health care ducats to patients and documentation of the re-routing.

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- c. The patient is responsible to report to the health care appointment at the time indicated on the priority health care ducat.
  - d. Developmental Disability Program/Disability Placement Program designated patients shall be provided specific instruction regarding the time and location of their scheduled appointment. The custody staff delivering the priority health care ducats shall communicate effectively and appropriately based upon the patient's ability to understand to ensure that the patient(s) arrives at the designated appointment location.
2. Custody staff shall ensure delivery of priority health care ducats to patients prior to their scheduled appointment.
3. Failure to Report for a Medical and/or Dental Appointment
  - a. If the patient (including patients who are in the Mental Health Services Delivery System) fails to report to a scheduled medical and/or dental appointment, the assigned health care access clinic officer shall immediately contact the designated housing unit or work/program assignment to locate the patient and have him/her escorted or have the patient report to the scheduled medical and/or dental appointment.
  - b. Custody staff shall locate the patient and escort the patient to the appointment or direct the patient to report to the scheduled medical and/or dental appointment. If necessary, custody staff shall order the patient to comply with the instructions on the priority ducat.
    - 1) If the patient continues to refuse, custody staff shall advise the patient that he/she is in violation of Title 15, Section 3014, Calls and Passes, which states "Inmates must respond promptly to notices given in writing, announced over the public address system, or by any other authorized means."
    - 2) If the reason the patient did not report as ducated was beyond the patient's control (e.g., out to court), custody staff shall advise health care staff of this fact.
    - 3) If the reason the patient did not report as ducated was due to the patient refusing to report as directed, custody staff shall escort the patient to the health care area for health care staff to discuss the implications of refusing health care treatment. Licensed health care staff shall counsel the patient and have the patient sign the CDCR 7225, Refusal of Examination and/or Treatment, if the patient continues to refuse treatment after the counseling. The CDCR 7225 shall be filed in the health record.
    - 4) Patients who are insistent in their refusal to report shall not be subject to cell extraction or use of force to gain compliance with the priority health care ducat. In these instances, licensed health care staff must respond to the patient's housing unit to provide the necessary patient education regarding the refusal. Custody staff cannot accept refusals on behalf of the patient, nor can refusals be taken over the phone.
    - 5) The reason for the failure to report shall be documented by health care staff on an Interdisciplinary Progress Note in the health record.
    - 6) Custody staff shall be responsible to document the patient's refusal to report to the priority health care ducat on a CDC 115, Rules Violation Report.
  - c. Medical and/or dental appointments shall be rescheduled as clinically indicated.

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4. Failure to Report for a Mental Health Appointment
  - a. If a patient in the Mental Health Services Delivery System refuses to report for a mental health appointment in person, custody staff shall not complete a CDC 115 or a Counseling Only Rules Violation Report (formerly known as a CDCR 128A, Custodial Counseling Chrono).
  - b. Refer to the CDCR Mental Health Services Delivery Systems Program Guide, 2009 Revision, for additional procedures regarding mental health appointment refusals.

## **D. Lockdown and Other Security Concerns**

1. Health care services shall continue to be provided during alarms/incidents not occurring on the clinic yard. For alarms/incidents occurring on the clinic yard, clinic services shall resume as soon as safely possible during and following the alarms/incidents.
2. During a facility or prison lockdown, health care staff shall coordinate with custody staff to facilitate continuity of care. Custody personnel shall escort patients to scheduled clinic appointments; lockdown shall not prevent the completion of scheduled medical appointments.
3. In restricted housing units and facilities/housing units on lockdown status, a system shall be maintained to provide patient access to health care services. Access to health care services shall be accomplished via daily cell front rounds by health care staff for the collection of the CDCR 7362. The rounds and collection of the CDCR 7362 shall be documented by nursing staff in the housing unit logbook.

## **E. Security Precautions During Health Care Encounters**

1. Health care encounters shall be provided in a manner that affords both auditory and visual confidentiality consistent with security and safety concerns of patients and health care providers.
2. Health care staff shall carry a whistle and, where available, a personal alarm and position themselves to have a clear egress route from the treatment room while performing assigned duties.
3. Health care screenings, evaluations, interviews, and treatment shall be held in a private setting unless the security of the institution or safety of staff will be compromised, or unless health care staff in the presence of the patient requests the presence of custody staff. As a default, custody staff is not required during a health care encounter with a patient who is not maximum custody or whose current behavior does not present a threat to the safety of staff or other patients.
  - a. A patient shall not be placed in mechanical restraints during a health care encounter unless they are a safety concern for staff or others as determined by custody staff.
  - b. Health care staff may ask custody staff to leave the room if they are comfortable with the patient and custody staff shall respect the request of health care staff and leave the room.
  - c. If health care staff asks custody staff to exit the room and leave the door propped open, custody staff shall be in control of the door to remain in compliance with State Fire Marshall requirements.
4. A treatment module shall be utilized for the duration of encounters with patients who are a safety and security risk.
  - a. Upon removal of the mechanical restraints, the front port on the module shall be closed during the encounter.
  - b. Health care staff shall not put their face in or near the opening of a cuff or food port.

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- c. If it is necessary to perform a procedure, the patient shall be removed from the treatment module and placed in waist restraints while being treated outside the module.
5. When health care staff are in housing units or on the tiers, custody staff shall maintain visual surveillance.
  - a. Visual surveillance shall not interfere with the privacy of the encounter with the exception of cell front medication distribution.
  - b. When unscheduled clinical encounters need to occur within a housing unit, staff shall conduct the encounter in a confidential setting with custody staff maintaining visual observation when necessary.

## **F. Clinic Closure / Cancellation of Scheduled Appointments**

Any modification of clinic hours, clinic closure, and cancellation or rescheduling of scheduled appointments requires the approval of the CEO or a designated clinical executive.

## **G. Timeframes**

1. Under the Complete Care Model, the goal of all Care Teams is to provide timely access to care and whenever possible “complete today’s work today” to allow immediate access to necessary services.
  - a. To ensure that patients are not exceeding acceptable thresholds for timely care, access to care timeframes should be viewed as the maximum allowable timeframe that a patient may be seen and not as a guideline for scheduling.
  - b. Scheduling Support Staff shall set appointments several days in advance of the acceptable threshold.
2. Patients with chronic conditions shall have follow-up encounters according to the timeframes in the applicable care guides. If there is no applicable care guide, the follow-up shall be as ordered or no less frequently than 365 days.
3. Patients discharged to an outpatient setting from the TTA who are clinically high risk shall be seen by their PCP within 5 calendar days of discharge. Patients discharged to an outpatient setting from the TTA who are clinically low or medium risk shall be seen by their Primary Care RN or PCP as clinically indicated.
4. Patients discharged to an outpatient setting from a community hospital, emergency department, or any non-mental health CDCR health care bed shall be seen by their PCP within 5 calendar days of discharge.
5. Patients discharged to an Enhanced Outpatient Program level of care from a Mental Health Crisis Bed (MHCB) or Psychiatric Inpatient Program (PIP) bed shall be seen by the Mental Health RN Care Manager within 3 calendar days of discharge and by a psychiatrist within 14 calendar days of discharge.
6. Patients discharged from a MHCB or PIP bed to a Correctional Clinical Case Management System Program level of care, and on psychiatric medications at present or in the last 6 months shall be seen by a psychiatrist within 14 calendar days of discharge.
7. If the MHCB or hospital psychiatrist asks that a patient be seen sooner than 14 calendar days after discharge, the psychiatrist’s order for when the patient should be seen shall be followed.

## **H. Scheduling Queues and Building the Clinic Schedule**

Health care staff shall place orders for appointments that need to be scheduled, which will flow into various request queues in the scheduling system. Scheduling Support Staff are

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responsible for monitoring the appropriate request queue for each Care Team and clinic location daily with particular focus on scheduling appointments for patients within several days of the relevant threshold date.

## **I. Increasing Patient Show Rates and Clinic Efficiency**

When scheduling patients, health care staff shall consider patient preferences regarding access, such as providing appointment times that do not interfere with the patient's work shifts or classes.

## **J. Recurring Appointments**

Scheduling Support Staff shall use the recurring appointment function when a provider or clinician's order will result in a series of appointments with a specified frequency.

## **K. Rescheduling**

Scheduled appointments must be rescheduled if the appointment date or priority of the appointment changes.

## **L. Cancelling Appointments**

Health care staff are prohibited from cancelling appointments from the scheduling system.

## **M. Tracking "Reasons Not Seen"**

Health care staff shall record and track reasons that patients are not seen as scheduled. Health care staff shall use the standard "Reasons Not Seen" as listed in the scheduling system.

## **N. Confirmed Appointments Already Seen**

The Primary Care Scheduler, or designee, is responsible to contact members of the Care Team to obtain any missing information or address discrepancies.

## **O. Open Access**

1. Institutions shall use open access slots to ensure that patients are seen in an efficient manner, in a clinically appropriate setting, and within all mandated timeframes. Approximately 20 percent of Primary Care Clinic appointment slots shall remain open and available for same-day or next-day urgent clinical issues or appointments with short mandated timeframes.
2. Primary Care Clinics shall designate specific times each day as open access times for the Care Team.
3. During daily huddles, the Care Team shall identify patients that need to be scheduled into the same-day or next-day open access times and ensure that this information is communicated to the Scheduling Support Staff if he or she is not present at the huddle.
4. Appointments that may be appropriate for open access slots include, but are not limited to, the following:
  - a. Follow-up on abnormal diagnostic results or other critical abnormal clinical findings.
  - b. Community hospital discharge follow-up.
  - c. Urgent TTA follow-up.
  - d. High priority specialty referral follow-up.
  - e. High-risk/complex patients new to the Care Team.
  - f. Patients whose condition has become clinically complex.
  - g. Other urgent referrals.
5. If open access slots remain available even after all urgent follow-ups are addressed, these slots may be used to schedule other routine appointments.

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6. With the exception of certain clinics (e.g., Administrative Segregation) where patient need and health care staff coverage may vary, clinic schedules shall be booked 14-30 calendar days out (except for “Open Access” slots).

**P. Encounter Consolidation Appointments**

To increase clinic efficiency and timely access, Scheduling Support Staff shall review all pending appointments for possible encounter consolidation and discuss with the Care Team at the daily huddle to determine the total time required for the patient.

**Q. Co-Consultation**

Throughout the day, the Care Team shall look for opportunities to collaborate using co-consultation strategies to resolve issues in one encounter that would likely result in a referral to another member of the Care Team, thus eliminating the need for the patient to return to the clinic for a second time.

**R. Provision of Additional Health Care Staff During Examinations**

1. An additional health care staff shall be present during all examinations of patients involving genital, rectal, or breast examinations.
2. Upon patient request, an additional health care staff may be present during other examinations.

## VII. REFERENCES

- Code of Federal Regulations, Title 45, Parts 160 and 164. Health Insurance Portability and Accountability Act
- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 4, Article 2, Section 3270, General Policy
- California Code of Regulations, Title 15, Division 3, Chapter 1, Article 1, Section 3014, Calls and Passes
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapter 11, Patients’ Rights Policy
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapters 28.1 and 28.2, Effective Communication Policy and Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 1.4, Population and Care Management Services Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 12, Emergency Medical Response System Policies and Procedures
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision
- California Correctional Health Care Services, Security Precautions and Inmate Privacy During Health Care Encounters Memorandum, March 5, 2018
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center, <http://www.ahrq.gov/>
- The Joint Commission Primary Care Medical Home Certification, <http://www.jointcommission.org/accreditation/pchi.aspx>
- National Committee for Quality Assurance – Patient-Centered Medical Home Recognition, <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>